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Supreme Court, U.S.
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No. 07-

IN THE

Supreme Court of the United States

COOK CHILDREN'S MEDICAL CENTER,

Petitioner,

v.

THE NEW ENGLAND PPO PLAN OF GENERAL CONSOLIDATED MANAGEMENT INC; DEBORAH HANSEN, FIDUCIARY and NEW ENGLAND LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

THOMAS L. FREYTAG
P.O. Box 600124
Dallas, TX 75360
(214) 363-9501

Attorney for Petitioner

211988

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

QUESTION PRESENTED FOR REVIEW

This is a very simple case raising the issue of whether it is against public policy for a father, who has three children all covered by ERISA plan health-care benefits, to waive the ERISA plan benefits of only one child, (while continuing the coverage for the other two children in the ERISA plan), in order to obtain public Medicaid benefits for the very expensive medical treatment of the excluded child when there would be no additional premium for ERISA plan coverage of that child.

Did the Court of Appeals err in enforcing the father's waiver of available health-care benefits for his son, David C. Miller, under the New England Life ERISA plan even though the sole purpose of the waiver was to obtain Medicaid benefits for his son in contravention of public policy.

STATEMENT PURSUANT TO RULE 29.6

Petitioner, Cook Children's Medical Center, has no parent corporation and no publicly held company owns 10% or more of its stock.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED FOR REVIEW ...	i
STATEMENT PURSUANT TO RULE 29.6 ...	ii
TABLE OF CONENTS	iii
TABLE OF APPENDICES	iv
TABLE OF CITED AUTHORITIES	v
OPINIONS BELOW	1
STATEMENT OF JURISDICTION	1
STATUTES INVOLVED	1
STATEMENT OF THE CASE	4
REASONS FOR GRANTING THE PETITION ..	6
CONCLUSION AND PRAYER	12

TABLE OF APPENDICES

Page

Appendix A — Opinion Of The United States Court Of Appeals For The Fifth Circuit Filed June 28, 2007 ..... 1a

Appendix B — Amended Order Denying Motion To Alter And Amend Final Judgment Of The United States District Court For The Northern District Of Texas, Fort Worth Division Dated December 14, 2005 ..... 26a

Appendix C — Order Granting Summary Judgment Of The United States District Court For The Northern District Of Texas, Fort Worth Division Dated September 14, 2005 ... 28a

Appendix D — Order Of The United States Court Of Appeals For The Fifth Circuit Denying Petition For Rehearing Filed August 1, 2007 ..... 40a

TABLE OF CITED AUTHORITIES

Page

Cases

American Tobacco Co. v. U.S., 328 U.S. 781 (1946) 11

Beverly Health & Rehab. Serv. v. N.L.R.B., 317 F.3d 316 (D.C. Cir. 2003) 11

Hurd v Hodge, 334 U.S. 24 (1948) 9

Lynch v. Magnavox Co., 94 F.2d 883 (9th Cir. 1938) 10

Service Elec. Co., 281 L.L.R.B.633, 1986 WL 54372 (1986) 11

United of Omaha Life Ins. v. Sun Life Ins., 894 F.2d 1555 (11th Cir. 1990) 5

W.R. Grace & Co. v. Local Union 759, International Union of the United Rubber, Cork, Linoleum & Plastic Workers of America, 461 U.S. 757 (1983) 9

Cited Authorities

Page

Statutes, Regulations and Rules

28 U.S.C. § 1254 1

42 U.S.C. § 1320a-7b 2, 8

42 U.S.C. § 1396 *et seq.* (2000) 1, 6-7

42 U.S.C. § 1396k(a)(1)(A) 5

42 C.F.R. §433.139(b)(1) 7

42 C.F.R. §433.139(c) 8

42 C.F.R. §433.139(d)(2) 8

42 C.F.R. 433.145 5

Texas Human Resource Code § 32.033(b) 3, 8

Rule § 354.2321(c), Title 1, Part 15, Chapter 354 Subchapter J, Texas Administrative Code ... 6

OPINIONS BELOW

The decision of the Fifth Circuit dated June 28, 2007, reported at 491 F.3d 266, is set forth in App. A.

The unreported decision of the U.S. District Court for the Northern District of Texas, Fort Worth Division, dated December 14, 2005, is set forth in App. B.

STATEMENT OF JURISDICTION

A timely petition for rehearing was denied on August 1, 2007. (App. D) The U.S. Supreme Court has jurisdiction to review this case under 28 U.S.C. § 1254.

STATUTES INVOLVED

42 U.S.C. § 1396. Appropriations.

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, **whose income and resources are insufficient to meet the costs of necessary medical services**, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or selfcare, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this § shall be used for making

payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance." (Emphasis supplied).

42 U.S.C. § 1320a7b - Criminal Penalties for Acts Involving Federal Health Care Programs provides in relevant part:

> **"(a) Making or Causing to be Made False Statements or Representations —**
>
> Whoever —
>
> (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),
>
> (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
>
> (3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a

greater amount or quantity than is due or when no such benefit or payment is authorized, . . . shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) *in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.*" (Emphasis supplied).

Texas Human Resource Code § 32.033(b) provides:

"(b) A person who applies for or receives medical assistance shall inform the department, at the time of application or at any time during eligibility and receipt of services, of any unsettled tort claim which may affect medical needs and of any private accident or sickness insurance coverage that is or may become available. A recipient shall inform the department of any injury requiring medical attention that is caused by the act or failure to act of some other person. An applicant or a recipient shall inform the department as required by this subsection

> within 60 days of the date the person learns of his or her insurance coverage, tort claim, or potential cause of action. An applicant or a recipient who knowingly and intentionally fails to disclose the information required by this subsection commits a Class C misdemeanor."

STATEMENT OF THE CASE

During the period from November 29, 2001, through March 31, 2002, the child David C Miller ("David C") was a covered dependent under the ERISA Group Health Plan which his father's employer provided through Aetna U.S. Healthcare (the "Aetna plan".) (Cook Children's Record Excerpts, Tab 6, p.5). The Aetna plan terminated at 12:00PM on March 31, 2002, and immediately thereafter the employer's new ERISA plan (the "New England Life ERISA plan" — a self-funded plan with insurance coverage through New England Life Insurance Company) became effective. The New England Life ERISA plan provided automatic coverage to those covered, like David C, by the prior Aetna plan on the date the Aetna plan terminated, stating:

> "A member who had similar coverage under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan Effective date." (Cook Children's Record Excerpts, Tab 6, p.1.)

On March 31, 2002, while the Aetna plan was still in effect and before the New England Life ERISA plan became effective, David C's father directed that David C's name be stricken from an enrollment form pertaining

to the New England Life ERISA plan.[1] The father, by affidavit, said that he relinquished the right to have David C covered under the New England Life ERISA plan so that David C could obtain Medicaid benefits. Because the father's other two children were also covered by the New England Life ERISA plan, David C's cover by the plan would have required no additional premiums.

David C's parents requested Cook Children's Medical Center ("Cook Children's") to provide health-care services for David C who was afflicted with a debilitating congenital heart condition. The parents represented to Cook Children's that David C was not covered by health-care insurance but was covered by Medicaid. The parents executed an assignment of David C's rights to any health-care benefits to Cook Children's, as required by 42 U.S.C. § 1396k(a)(1)(A); 42 C.F.R. 433.145.

Cook Children's provided the requested health-care services to David C, the value of which totaled approximately $137,952.27. Cook Children's sought Medicaid reimbursement. Medicaid reimbursed Cook Children's $76,291.63. Thereafter, Cook Children's discovered that David C had been entitled to automatic coverage by the New England Life ERISA plan. Upon learning this, Cook Children's reimbursed Medicaid the money it had been paid, and then submitted its claim for reimbursement to the Plan Administrator of the New

[1] Automatic coverage by the plan made this enrollment form unnecessary. *United of Omaha Life Ins. v. Sun Life Ins.*, 894 F.2d 1555, 1559 (11th Cir. 1990) ("Because Wells was automatically covered by the basic insurance of the group policy, no application was necessary.")

England Life ERISA plan.[2] The Plan Administrator denied the claim on the basis that David C was not covered under the plan because his father had waived coverage for him.

Cook Children's sued the New England Life ERISA plan to enforce its claim for services provided to David C. The District Court held that the Plan Administrator's denial of the claim was not an abuse of discretion, and granted New England Life's motion for summary judgment and denied Cook Children's cross-motion for summary judgment. The U.S. Court of Appeals for the Fifth Circuit affirmed the District Court on June 28, 2007, and denied Cook Children's petition for rehearing on August 1, 2007.

REASONS FOR GRANTING THE PETITION

The father relinquished the health-care plan benefits and insurance resources automatically available to David C under the New England Life ERISA plan solely to qualify David C for Medicaid benefits.

The Medicaid program was established under title XIX of the Social Security Act and is codified at 42 U.S.C.

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[2] Rule § 354.2321(c) in Title 1, Part 15, Chapter 354, subchapter J of the Texas Administrative Code states:

> "Providers who identify a third-party, within 12 months from the date of service, and wish to submit a claim for payment to a third-party health insurer after a claim for payment has been submitted and paid by the Commission, must refund any amounts paid by Medicaid prior to submitting a claim for payment to the third party insurer."

§§ 1396 *et seq.* (2000). 42 U.S.C. § 1396 authorizes federal appropriations to the each State for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish *inter alia* "(1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, ***whose income and resources are insufficient*** *to* meet the costs of necessary medical services." (Emphasis added). Medicaid is a joint federal-state health-care financing program and one of the largest programs in the federal and state budgets. A state pays qualified health-care providers for a broad range of services provided to qualified beneficiaries, and the federal government reimburses the state for a share of its expenditures. The federal share is calculated according to a formula specified in the Medicaid statute.

The state Medicaid program must comply with federal policy and requirements, one of which is that Medicaid must be the *payor of last resort* and therefore the state Medicaid agency must avoid paying health-care costs for which a third-party resource, such as a group health-care plan or insurer, may be liable.

The state is responsible for having plans in place to identify a potential Medicaid beneficiary's other sources of health-care coverage. Whenever a state Medicaid agency establishes the "probable existence" of third party liability at the time a claim for medical services is filed, it must reject the claim and return it to the provider for a determination of the amount of liability. 42 C.F.R. § 433.139(b)(1). This process is called "cost avoidance" because it "avoids" the cost to Medicaid by preventing a claim from being paid by Medicaid in the first place.

If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the Medicaid agency must pay the full amount allowed under the agency's payment schedule. 42 C.F.R. § 433.139(c).

If the state Medicaid agency "learns of the existence of a liable third party or benefits become available from a third party after a claim is paid, the state Medicaid agency must seek recovery of reimbursement. . . ." 42 C.F.R. § 433.139(d)(2). This process is sometimes called "pay and chase".

A misrepresentation of or failure to disclose the facts about available health-care plan or insurance resources in order to qualify for Medicaid benefits is so contrary to the public interest that both the federal congress and Texas legislature have criminalized such conduct. *See, e.g.,* **42 U.S.C. § 1320a7b - *Criminal Penalties for Acts Involving Federal Health Care Programs — (a) Making or Causing to be Made False Statements or Representations*** —and ***Texas Human Resource Code § 32.033(b).*** (These statutes are reproduced at pages 2, 3 and 4, *supra*).

The father's attempt to qualify David C for Medicaid benefits by excluding him from the automatically available health-care benefits under the New England Life ERISA plan, circumvented and contravened the public policy embodied in the Medicaid statutes and regulations. That public policy is: (i) Medicaid funds are provided to help persons whose *resources are insufficient to meet the costs of necessary medical*

services; (ii) Medicaid is the *payor of last resort*; and (iii) other resources available to pay for health-care for the beneficiary must be obtained and paid for health-care costs before Medicaid benefits are available.

Consideration of this public policy was brushed aside by the Court of Appeals on the basis that it declined to impose a requirement on a plan administrator to determine whether a plan participant's election and waiver of plan benefits comports with Medicaid law. However, it ***is* a requirement for the *courts*** to make such a determination and to refuse to enforce an election and waiver that is contrary to the public policy declared in the Medicaid statute and regulations. In *Hurd v. Hodge*, 334 U.S. 24, 34-35 (1948), this Court declared:

> "The power of the federal courts to enforce the terms of private agreements is at all times exercised subject to the restrictions and limitations of the public policy of the United States as manifested in the Constitution, treaties, federal statutes, and applicable legal precedents. Where the enforcement of private agreements would be violative of that policy, it is the obligation of courts to refrain from such exertions of judicial power."

And in *W.R. Grace & Co. v. Local Union 759, International Union of the United Rubber, Cork, Linoleum & Plastic Workers of America*, 461 U.S. 757,766 (1983), this court said:

> "As with any contract, however, a court may not enforce a collective bargaining agreement

> that is contrary to public policy. See *Hurd v. Hodge*, 334 U.S. 24, 3435 (1948) . . . If the contract as interpreted by Barrett violates some explicit public policy, we are obliged to refrain from enforcing it. *Hurd v. Hodge*, 334 U.S., at 35."

The Court of Appeals was thus obliged to refrain from enforcing the father's purported waiver of health-care benefits automatically available for David C under the New England Life ERISA plan, a waiver that the father expressly stated was made solely for the purpose of obtaining Medicaid benefits for David C.

The summary plan description of the New England Life plan provided that a plan participant could "elect not to be covered under this Plan for any benefits, or may waive coverage for all coverages except Life and AD&D Insurance, or may waive coverage for medical and prescription drug only." However, this provision, relied on by the Plan Administrator and both courts below, does not sanitize a participant's wrongful election or waiver that was made solely to accomplish the unlawful purpose of obtaining Medicaid benefits when plan benefits for David C's health-care costs were automatically available. *See Lynch v. Magnavox Co.*, 94 F.2d 883, 890 (9th Cir. 1938):

> "Therefore, here, it is insufficient to contend that there is no violation of the act because the means agreed upon were lawful. If the purpose was unlawful there is a violation . . . . As a corollary to the first line of argument, it is also contended that the actual use of the

> various means related was lawful. The argument is pertinent only if there was no unlawful purpose. Thus, the arguments, relating to the means agreed upon and used as being lawful means, are wide of the mark, unless there is a total failure to allege an unlawful purpose; and it is here evident that there was such an unlawful purpose alleged."

See also American Tobacco Co. v. U.S., 328 U.S. 781, 809 (1946):

> "It is not of importance whether the means used to accomplish the unlawful objective are in themselves lawful or unlawful. Acts done to give effect to the conspiracy may be in themselves wholly innocent acts. Yet, if they are part of the sum of the acts which are relied on to effectuate the conspiracy which the statute forbids, they come within its prohibition."

And compare *Service Elec. Co.*, 281 N.L.R.B. 633, 639 n. 11, 1986 WL 54372 (1986) (acknowledging that "the ability to set employment terms for replacements is a necessary incident of the underlying right to hire replacements" but noting that "*if the struck employer is exercising that right in a manner designed to accomplish an illegal objective*, i.e., to undermine the bargaining representative, then *there would be a basis for finding a violation*") (emphasis supplied) (followed in *Beverly Health & Rehab. Serv. v. N.L.R.B.*, 317 F. 3d 316, 326 (D.C. Cir. 2003).

CONCLUSION AND PRAYER

For the foregoing reasons the Court should grant certiorari. Petitioner so prays.

Respectfully submitted,

THOMAS L FREYTAG
P.O. Box 600124
Dallas, TX 75360
(214) 363-9501

Attorney for Petitioner

APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT FILED JUNE 28, 2007

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 06-10511

COOK CHILDREN'S MEDICAL CENTER

Plaintiff - Counter Defendant - Appellant

v.

THE NEW ENGLAND PPO PLAN OF GENERAL CONSOLIDATED MANAGEMENT INC; DEBORAH HANSEN, Fiduciary of the New England PPO Medical Plan of General Consolidated Management, Inc.

Defendants - Counter Claimants - Appellees

NEW ENGLAND LIFE INSURANCE COMPANY,

Third Party Defendant - Appellee

Appeal from the United States District Court for the Northern District of Texas

Before KING, GARZA, and PRADO, Circuit Judges.

Appendix A

PRADO, Circuit Judge:

Cook Children's Medical Center appeals the district court's grant of summary judgment and award of mediation costs in favor of the defendants. For the reasons that follow, we AFFIRM the district court's order granting summary judgment and VACATE the award of mediation fees as taxable costs under 28 U.S.C. § 1920.

I. BACKGROUND

A. Factual Background

David G. Miller ("Mr. Miller") began his employment with Creative Education Inc., a company affiliated with General Consolidated Management, Inc. ("General Consolidated"), in September 2000. General Consolidated has a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461, which provides medical and other benefits to its employees and their beneficiaries.

On January 16, 2002, Mr. Miller asked General Consolidated to add his son, David C. Miller ("David"), as a covered dependent under General Consolidated's ERISA plan, which at that time was insured through Aetna U.S. Healthcare. David was born on November 29, 2001, with congenital heart defects and other disabilities.

Appendix A

In early 2002, General Consolidated decided to no longer fund its ERISA plan through Aetna U.S. Healthcare. Effective April 1, 2002, General Consolidated replaced the Aetna Plan with a self-funded ERISA plan, under which New England Life Insurance Company ("New England") provided excess coverage and administrative services for the plan. The open enrollment period for the new plan, the New England PPO Medical Plan of General Consolidated Management, Inc. ("Plan"), began on March 1, 2002, and ended on March 31, 2002.

On March 2, 2002, Mr. Miller filled out a Benefit Plan Enrollment/Change Form for the Plan and listed David as one of his dependents to be enrolled in the Plan. On March 31, 2002, Mr. Miller removed David from his Plan enrollment form by crossing through David's name and information. Underneath the line crossing through David's name and information is a handwritten note on the enrollment form stating "[t]ake off per [Mr. Miller]. [David] is on Medicaid. 3-31-02. Phoned Irene." In addition, Mr. Miller told Cathy Gunn of General Consolidated that David should not be enrolled in the Plan as one of his covered dependents. Mr. Miller took these actions during the open enrollment period and before the Plan's effective date. Pursuant to Mr. Miller's instructions, the Plan Administrator, Deborah Hansen ("Plan Administrator"), did not enroll David in the Plan.

Mr. Miller's decision not to enroll David in the Plan was based on conversations he and his wife, Amy Miller ("Mrs. Miller"), had with Medicaid and Social Security

Administration representatives. These representatives allegedly told the Millers that David's medical care would be covered by Medicaid if Mr. Miller did not enroll David in the Plan.

David was covered by Medicaid in April 2002, and his Medicaid coverage continued until June 30, 2002. From April 9-22, 2002, David underwent medical treatment at Cook Children's Medical Center ("Cook"). When David was admitted for treatment, the Millers informed Cook that David was covered by Medicaid. In addition, the Millers assigned to Cook any benefits to which David was entitled.[1]

Cook filed its claim for David's hospital bills with Medicaid. Medicaid paid Cook approximately $76,291.63 for David's medical treatment in April 2002.[2]

In June 2002, the Millers were notified that David's Medicaid coverage would expire on June 30, 2002, because the Social Security Administration had determined that as of June 30, David would no longer qualify for supplemental security income. Because David's Medicaid coverage was set to expire on June 30, Mr. Miller submitted a Benefit Plan Enrollment/Change

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1. The assignment of benefits transferred to Cook all rights of the patient, David C. Miller, and was signed by Mrs. Miller.

2. Although Cook's invoices show charges of $145,435.92, Medicaid paid for services at its discounted rate.

Form on June 28, adding David to the Plan effective July 1, 2002. In a letter dated June 30, 2002, Mr. Miller stated:

> I wish to add [David] to my policy . . . effective 7/1/02. He was not enrolled during open enrollment because he was covered under Medicaid. I received a letter of denial from SSI Medicaid on June 11, 2002 stating he would no longer be eligible for coverage after 6/30/02.

The Plan enrolled David as of July 1, 2002.

After initially accepting payment from Medicaid for David's April 2002 treatment, Cook later returned Medicaid's $76,291.63 payment.[3] On December 31, 2002, Cook sent the Plan a demand letter, requesting that the Plan pay for David's medical services from April 9-22, 2002, in the amount of $137,952.27.

The Plan Administrator reviewed Cook's request for payment. The Summary Plan Description ("SPD") provides that

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3. At oral argument, counsel for Cook stated that Cook returned the Medicaid payment because Cook believed David was covered by the Plan provided by Mr. Miller's employer at the time services were rendered by the hospital. Counsel further explained that although Cook was not compelled to return the payment to Medicaid, Cook was permitted by Texas law to return Medicaid's payment and seek payment from the Plan. *See* 1 Tex. Admin. Code § 354.2321(c).

Appendix A

> [t]he Plan Administrator has complete authority to control and manage the Plan. The Plan Administrator has full discretion to determine eligibility, to interpret the Plan and to determine whether a claim should be paid or denied, according to the provisions of the Plan as set forth in this booklet.

The Plan Administrator determined that David was not eligible for coverage for his treatment at Cook in April 2002 because Mr. Miller had not enrolled David in the Plan at that time. In making this determination, the Plan Administrator looked to language in the SPD, which provides that a plan participant "may elect not to be covered under this Plan for any benefits, or [ ] may waive coverage for all coverages except Life and AD&D Insurance, or [ ] may waive coverage for medical and prescription drug only." Based on the administrative record, the Plan Administrator found that during the open enrollment period, Mr. Miller had removed David from his Benefit Plan Enrollment/Change Form by crossing through David's name and by telling Cathy Gunn of General Consolidated to remove David from his enrollment form. The Plan Administrator noted that it was not until July 1, 2002, that Mr. Miller enrolled David in the Plan. Accordingly, because David was not enrolled in the Plan during his treatment at Cook, the Plan Administrator denied Cook's request for payment.

Appendix A

B. Procedural History

On September 5, 2003, Cook filed this lawsuit against the Plan and the Plan Administrator. Cook alleged that David was a covered dependent under the Plan and that as David's assignee, it was entitled to recover payment for David's treatment in April 2002. The Plan and the Plan Administrator answered Cook's complaint and filed a third-party complaint against New England for indemnification. The parties conducted discovery and attended mediation,[4] which was not successful.

The parties subsequently filed cross-motions for summary judgment. On September 14, 2005, the district court granted summary judgment in favor of the Plan, the Plan Administrator, and New England (collectively, "Defendants"), and denied Cook's motion for summary judgment. The district court relied in part on Mr. Miller's affidavit, in which Mr. Miller averred in relevant part that:

> Neither the Plan, Hansen [the Plan Administrator], General Consolidated, New England nor anyone affiliated with them had

4. In its initial scheduling order, the district court set a deadline for the parties to participate in a formal settlement conference. The parties informed the district court that they thought mediation would be more productive than a settlement conference and requested that the district court extend the settlement conference deadline so that they could mediate the case. Thereafter, the district court extended the deadline for the parties to conduct a settlement conference or mediation.

any input into my wife's and my decision not to enroll David C. in the Plan. Nothing they said or did caused me to decide not to enroll David C. in the Plan. Additionally, I did not look to any of them for advice on whether to enroll David C. in the Plan and never asked them for any advice. This was a decision that my wife and I made by ourselves after discussing the matter with people affiliated with Medicaid and The Social Security Administration.

. . . .

When I instructed General Consolidated not to enroll David C. in General Consolidated's ERISA Plan, I knew I had the opportunity to have David C. as a named dependent under my health plan. However, I intentionally and voluntarily relinquished my right and David C.'s right to have him named as a dependent and plan member under my employer's ERISA health plan. I am college educated and had close to a month to make this decision. I had the opportunity to speak to an attorney or seek other assistance. This decision was made after multiple conversations with representatives of Medicaid and The Social Security Administration. From our perspective, this decision was made by my wife and I in the best interests of my family and David C: I did not intend to mislead anyone

by removing my son from the enrollment form. I do not feel that I have been misled by anyone.

The district court reasoned that because Mr. Miller elected not to have David enrolled in the Plan and knowingly and voluntarily waived David's coverage under the Plan, the Plan Administrator had a valid basis for denying benefits and such denial was not an abuse of discretion. That same date, the district court entered a final judgment, dismissing all claims with prejudice and taxing all costs under 28 U.S.C. § 1920 against Cook. The bill of costs submitted by Defendants included mediation fees in the amount of $1000.

Cook now appeals the district court's grant of summary judgment and award of mediation costs. We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1291.

II. STANDARDS OF REVIEW

This court reviews de novo a district court's grant of summary judgment. *See Mello v. Sara Lee Corp.*, 431 F.3d 440, 443 (5th Cir. 2005). Summary judgment is warranted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." FED. R. CIV. P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986).

An award of costs is reviewed for abuse of discretion. *See Lain v. UNUM Life Ins. Co. of Am.*, 279 F.3d 337, 343 (5th Cir.2002). "A district court abuses its discretion if it bases its decision on an erroneous view of the law or on a clearly erroneous assessment of the evidence." *Esmark Apparel, Inc. v. James*, 10 F.3d 1156, 1163 (5th Cir. 1994) (citing *Cooter & Gell v. Hartmarx Corp.*, 496 U.S. 384, 405-06, 110 S.Ct. 2447, 110 L.Ed.2d 359 (1990)).

III. DISCUSSION

A. Denial of Benefits

Cook argues that the Plan Administrator abused her discretion in denying payment to Cook for David's treatment, and that the district court's contrary conclusion was in error. Cook contends that David was automatically enrolled in the Plan because the SPD provides that "[a] Member who had similar coverage under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan effective date."[5] Cook maintains that any attempts by Mr. Miller to waive his son's coverage were ineffective and against public policy. More specifically, Cook submits that because Medicaid is the payor of last resort, it was illegal for Mr. Miller to exclude David from his Plan in order to obtain Medicaid coverage. Cook also claims that the district court should have afforded less deference to the Plan Administrator because there was an inherent

5. A "Member" is defined by the SPD as "[a]n employee and any covered Dependent."

conflict of interest in that Defendants benefitted financially from denying Cook's claim.

We begin with Cook's argument on the appropriate standard of review and then address the merits of the district court's determination that the Plan Administrator did not abuse her discretion.

1. Standard of Review

"Whether the district court employed the appropriate standard in reviewing an eligibility determination made by an ERISA plan administrator is a question of law," which we review de novo. *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 269 (5th Cir. 2004) (internal quotation marks and citation omitted). "When, as here, the language of the plan grants discretion to an administrator to interpret the plan and determine eligibility for benefits, a court will reverse an administrator's decision only for abuse of discretion." *High v. E-Systems Inc.*, 459 F.3d 573, 576 (5th Cir. 2006). " '[O]ur review of the administrator's decision need not be particularly complex or technical; it need only assure that the administrator's decision fall somewhere on a continuum of reasonableness-even if on the low end.' " *MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 478 (5th Cir. 2003) (quoting *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (en banc)). In making this determination, "we focus on whether the record adequately supports the administrator's decision." *Vega*, 188 F.3d at 298; *see also High*, 459 F.3d at 576 (stating

that the administrator's decision must be supported by substantial evidence in the record).

The existence of a conflict of interest, however, is a factor in the abuse of discretion inquiry. *Chacko v. Sabre, Inc.*, 473 F.3d 604, 610 (5th Cir. 2006). "When a conflict of interest is shown to exist, we apply a 'sliding scale,' giving less deference to the administrator's decision in proportion to the administrator's conflict." *Id.* "This approach does not mark a change in the applicable standard, but only requires the court to reduce the amount of deference it provides to an administrator's decision." *MacLachlan*, 350 F.3d at 478. "The degree to which a court must abrogate its deference to the administrator depends on the extent to which the challenging party has succeeded in substantiating its claim that there is a conflict." *Id.* at 479. "The greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be." *Vega*, 188 F.3d at 297. "Where, however, only 'a minimal basis for a conflict is established,' we review the decision with 'only a modicum less deference than we otherwise would.' " *MacLachlan*, 350 F.3d at 479 (quoting *Lain*, 279 F.3d at 343).

In an effort to substantiate its claim that there is a conflict, Cook points out that General Consolidated funds and administers its own medical benefit plan. This evidence, however, demonstrates only a "minimal basis for a conflict." *See Chacko*, 473 F.3d at 610 (finding a minimal basis for a conflict where the plaintiff demonstrated that his former employer funds and

administers its own plan, "leav[ing] open the possibility that it would limit claims to reduce its liability"). Cook has presented no evidence with respect to the degree of the conflict. *See id.*; *see also Vega*, 188 F.3d at 301. Accordingly, under our sliding scale approach, "we [ ] review the administrator's decision with only 'a modicum less deference' than we otherwise would." *Chacko*, 473 F.3d at 610 (quoting *Vega*, 188 F.3d at 301).

2. Analysis

In this circuit, application of the abuse of discretion standard involves a two-step process. *See Vercher v. Alexander & Alexander Inc.*, 379 F.3d 222, 227 (5th Cir. 2004). The court must first determine whether the administrator's plan interpretation is legally correct. *Id.* If the administrator's interpretation is legally sound, then the inquiry ends because no abuse of discretion could have occurred. *Chacko*, 473 F.3d at 611. On the other hand, if the court concludes that the administrator did not give the plan the legally correct interpretation, the court must then determine whether the administrator's decision was an abuse of discretion. *Id.*

"This court, however, is not confined to this test; we may skip the first step if we can determine the decision was not an abuse of discretion." *High*, 459 F.3d at 577; *see MacLachlan*, 350 F.3d at 481. Therefore, in assessing whether the Plan Administrator abused her discretion in denying Cook's claim on the basis that David was not enrolled in the Plan in April 2002, our analysis bypasses whether the Plan Administrator's interpretation was

legally correct, as the record reflects that she did not abuse her discretion.

The Plan Administrator's decision finds ample support in the record. The SPD specifically provides that an employee may opt out of any of the offered benefits, and nothing in ERISA precludes a plan participant from making a prospective election about his coverage in an ERISA health plan. *Cf. Dist. 29, United Mine Workers of Am. v. New River Co.*, 842 F.2d 734, 737 (4th Cir. 1988) (recognizing that no provision in ERISA precludes the knowing and voluntary relinquishment of employee health benefits). The evidence in the record shows that Mr. Miller chose not to enroll David in the Plan during the open enrollment period and before the effective date of the Plan, when Mr. Miller had an existing right to make changes to his coverage.[6] Because David was not enrolled in the Plan in April 2002 when he received medical

6. Cook challenges our reliance on Mr. Miller's affidavit, in which Mr. Miller stated that he decided "not to enroll David C. in the Plan," that he "instructed General Consolidated not to enroll David C. in General Consolidated's ERISA Plan," and that he "intentionally and voluntarily relinquished [his] right and David C.'s right to have him named as a dependent and plan member under [his] employer's ERISA health plan." Specifically, Cook argues that it never had an opportunity to cross-examine Mr. Miller on his affidavit. Cook's contention is too little, too late. "A party cannot evade summary judgment simply by arguing that additional discovery is needed, and may not simply rely on vague assertions that additional discovery will produce needed, but unspecified, facts." *Adams v. Travelers Indem. Co. of Conn.*, 465 F.3d 156, 162 (5th Cir. 2006) (internal quotation marks and citations omitted).

services at Cook, the Plan Administrator did not abuse her discretion in denying Cook's claim.

Cook's contention that David was automatically enrolled in the Plan, thereby making this an issue of waiver, does not change our conclusion. Even if we were to accept Cook's argument that David was automatically enrolled under the terms of the Plan, the Plan Administrator still did not abuse her discretion in denying Cook's claim because Mr. Miller voluntarily waived David's coverage. "[W]aiver is the intentional relinquishment or abandonment of a known right or privilege." *HECI Exploration Co. Employees' Profit Sharing Plan v. Holloway (In re HECI Exploration Co.)*, 862 F.2d 513, 523 (5th Cir. 1988); *see also High*, 459 F.3d at 581. This circuit has stated, in the context of an employee welfare benefit plan governed by ERISA, that "a waiver is valid if it is 'explicit, voluntary and made in good faith.' " *Guardian Life Ins. Co. of Am. v. Finch*, 395 F.3d 238, 240 (5th Cir. 2004) (quoting *Manning v. Hayes*, 212 F.3d 866, 871 (5th Cir. 2000)). The record evidence indicates that Mr. Miller, who is college educated, knowingly and voluntarily decided not to enroll David in the Plan, even though Mr. Miller knew he had the opportunity to have David as a named dependent under the Plan. It therefore was not an abuse of discretion for the Plan Administrator to deny Cook's claim.

Finally, Cook's argument that Mr. Miller's prospective election not to cover David is void as a matter of public policy does not affect our analysis regarding

whether the Plan Administrator abused her discretion. This court has never imposed a requirement on a plan administrator to determine whether a plan participant's election comports with Medicaid law, and we decline to do so today. All that ERISA requires is that substantial evidence support the administrator's decision to deny a claim, when, as here, the administrator is vested with the discretion to determine eligibility for plan benefits. Because the record here adequately supports the Plan Administrator's decision, we find no error in the district court's decision to uphold the Plan Administrator's denial of Cook's claim.[7]

B. Award of Mediation Costs

Cook argues that the district court should not have taxed mediation costs against it because mediation expenses do not fall within the limited category of costs that may be taxed under 28 U.S.C. § 1920. In support of its position, Cook points to *Mota v. University of Texas Houston Health Science Center*, 261 F.3d 512 (5th Cir. 2001).

In *Mota*, this court addressed whether the district court had abused its discretion in taxing mediation fees under § 1920 in a Title VII action. 261 F.3d at 529-30. The *Mota* court began its analysis by examining 28 U.S.C. § 1920. *See id.* at 529. Under § 1920, a court may tax the following costs:

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7. Accordingly, we need not address Defendants' alternative arguments in favor of affirming the district court.

(1) Fees of the clerk and marshal;

(2) Fees of the court reporter for all or any part of the stenographic transcript necessarily obtained for use in the case;

(3) Fees and disbursements for printing and witnesses;

(4) Fees for exemplification and copies of papers necessarily obtained for use in the case;

(5) Docket fees under section 1923 of this title;

(6) Compensation of court appointed experts, compensation of interpreters, and salaries, fees, expenses, and costs of special interpretation services under section 1828 of this title.

The court noted that "[t]he Supreme Court has indicated that federal courts may only award those costs articulated in section 1920 absent explicit statutory or contractual authorization to the contrary." *Id.* (citing *Crawford Fitting Co. v. J.T. Gibbons, Inc.*, 482 U.S. 437, 444-45, 107 S.Ct. 2494, 96 L.Ed.2d 385 (1987)).

Turning to the text of § 1920, the *Mota* court concluded that the district court "erred in taxing [the losing party] with the costs of mediation [because the

expense did not fall] within section 1920." *Id.* at 530. The court further determined that nothing in Title VII supported the award of mediation fees because "mediation costs do not fall within the limited category of expenses taxable under Title VII." *Id.; see also* 42 U.S.C. § 2000e-5(k) (providing that "the court, in its discretion, may allow the prevailing party, other than the Commission or the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the Commission and the United States shall be liable for costs the same as a private person").

The reasoning in *Mota* cuts against the district court's decision to award mediation fees in this ERISA case. First, the language in § 1920 has not changed since the *Mota* court concluded that mediation fees do not fall within any of the categories of expenses listed in the statute. Second, like Title VII's provision on costs, the applicable ERISA subsection on costs does not explicitly authorize the award of mediation expenses. *See* 29 U.S.C. § 1132(g)(1) ("[T]he court in its discretion may allow a reasonable attorney's fee and costs of action to either party.").

Defendants assert, however, that *Mota* is limited to Title VII cases and should not be applied in this ERISA action. Defendants instead point to this circuit's en banc decision in *Gaddis v. United States*, 381 F.3d 444 (5th Cir.2004), as support for the district court's award of mediation fees in this case. According to Defendants, mediation fees are recoverable expenses because

mediators essentially act as court appointed experts, a cost recoverable under § 1920(6).

We disagree. In *Gaddis*, the court held that district courts may tax guardian *ad litem* fees as court costs against nonprevailing parties, including the government in Federal Tort Claims Act cases. 381 F.3d at 447. In analyzing the issue, the court identified three alternative grounds for permitting the taxation of guardian *ad litem* fees. First, the court reasoned that Federal Rule of Civil Procedure 17(c) constituted the alternative express statutory authorization required by the Supreme Court in *Crawford Fitting* to provide district courts with the inherent authority and discretion to tax guardian *ad litem* fees as costs against nonprevailing parties.[8] *Id.* at 452-55. Second, the court determined that guardians *ad litem* reasonably fit within the meaning of the phrase "court appointed experts" in § 1920(6), thereby allowing district courts to tax their compensation as costs per § 1920. *Id.* at 455-57. And third, the court reasoned that precedent subsequent to *Crawford Fitting* allowed for the taxation of guardian *ad litem* fees as costs. *Id.* at 457-59.

None of the three alternate grounds for permitting the taxation of guardian *ad litem* fees in *Gaddis* is applicable to the taxation of mediation expenses here.

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8. Rule 17(c) provides in relevant part: "The court shall appoint a guardian ad litem for an infant or incompetent person not otherwise represented in an action or shall make such other order as it deems proper for the protection of the infant or incompetent person."

First, there is no statutory or contractual provision that permits the taxation of the cost in question. As explained above, the ERISA statute on costs, 29 U.S.C. § 1132(g)(1), does not constitute an explicit authorization to tax mediation costs, nor does it seem reasonable to construe the provision as a blanket power to tax costs. *See Agredano v. Mut. of Omaha Cos.*, 75 F.3d 541, 544 (9th Cir. 1996) (holding that § 1132(g)(1)'s "allowance for 'costs of action' empowers courts to award only the types of 'costs' allowed by 28 U.S.C. § 1920"); *cf. Holland v. Valhi Inc.*, 22 F.3d 968, 979-80 (10th Cir. 1994) (rejecting the argument that 29 U.S.C. § 1132(g)(1) expressly authorized taxation of expert witness fees). Likewise, the source of the district court's authority to authorize the use of mediation in a civil action does not support the taxation of mediation fees. *See* 28 U.S.C. §§ 651-652. There is absolutely nothing in these statutory provisions that would expressly or implicitly provide district courts with the inherent authority or discretion to award mediation fees as costs.

Second, unlike the guardian *ad litem* fees in *Gaddis*, mediation expenses do not reasonably fit within the statutory language of § 1920(6), which allows for "[c]ompensation of court appointed experts." Nowhere does the statute define "court appointed experts."[9] That

9. In *Gaddis*, this court concluded that we are not constrained to define "court appointed experts" as that term is used in Federal Rule of Evidence 706. 381 F.3d at 456-57 ("While there is some indication in the legislative history that court appointed expert as used in § 1920(6) refers to a court appointed

(Cont'd)

term is defined elsewhere as an "impartial expert" or as "[a]n expert who is appointed by the court to present an unbiased opinion." Black's Law Dictionary 619 (8th ed. 2004).

Although the court in *Gaddis* did not define court appointed expert, it identified two characteristics that indicate when one "reasonably serve[s] as [an] expert[ ]." 381 F.3d at 456. The court explained that

> guardians *ad litem* appointed by the court reasonably serve as experts in the sense that they liaise with the court and are charged with the important duty of providing their insight as to how the judicial process is or is not comporting with the best interests of the minor or incompetent person involved.

Id. Under the *Gaddis* interpretation, experts "liaise with the court" on the matter in which the court requires assistance and "are charged with the important duty of providing their insight" to the court regarding that aspect of the case. *See id.* The *Gaddis* court reasoned that guardians *ad litem* reasonably fit within the

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(Cont'd)
expert as appointed pursuant to Federal Rule of Evidence 706, the plain statutory language of § 1920(6) does not so narrowly limit the interpretation of court appointed expert. This *en banc* Court is thus not constrained to so narrowly interpret the category of court appointed expert.") (internal citation omitted). *Contra In re Cardizem CD Antitrust Litig.*, 481 F.3d 355, 363-64 (6th Cir. 2007).

definition of "court appointed experts" under § 1920(6) because a "guardian *ad litem*'s special duty is to submit to the court for its consideration and decision every question involving the statutory and constitutional rights of the minor that may be affected by the action." *Id.*

Turning to the issue of whether a mediator reasonably fits within the scope of a court appointed expert, we examine the definition and role of a mediator. The prevailing definition of a mediator is "[a] neutral person who tries to help disputing parties reach an agreement." Black's Law Dictionary 1003 (8th ed. 2004); *see also* 1 Jay E. Grenig, Alternative Dispute Resolution § 4.1 (3d ed. 2005) (stating that "[m]ediation involves a neutral third party—the mediator-whose function is to assist the parties in their negotiations"). Similarly, the Uniform Mediation Act defines mediation as "a process in which a mediator facilitates communication and negotiation between parties to assist them in reaching a voluntary agreement regarding their dispute." Unif. Mediation Act § 2(1) (2001).

From these descriptions it is apparent that, in contrast to guardians *ad litem*, mediators lack the essential characteristics of court appointed experts, under both the general definition and the interpretation of the *Gaddis* court. First, the role of mediators is to facilitate negotiations between the parties in an unbiased manner, not to liaise with the court. As a result, mediators "usually deal[ ] directly with the parties" during mediation and need not communicate with the court at all. *See* GRENIG, *supra*, § 4.41 (describing the

role of mediators in terms of interaction with the parties). In addition, because the discussions in mediation are frequently confidential, it is questionable whether a mediator could ethically communicate an opinion to a court at all. *See id.* § 4:10 (explaining that "[s]tatements made during mediation may be accorded protection by federal or state laws"); *see also* N.D. Tex. Civil Justice Expense & Delay Reduction Plan, at 6 (rev. May 2002) (providing that "[a]ll communications made during ADR procedures [including mediation] are confidential and protected from disclosure"). Indeed, aside from acting as neutral parties, mediators appear to share no other significant common qualities with court appointed experts. Therefore, mediators fall outside a reasonable interpretation of court appointed experts.

Third and finally, contrary to the precedent that supported the en banc court's decision in *Gaddis*, case law from this circuit and other circuits does not support the taxation of mediation fees as costs under § 1920. As discussed earlier, this court in *Mota* held that mediation fees are not taxable costs under § 1920. *See* 261 F.3d at 530. In addition to *Mota*, decisions from two other circuits have considered whether mediation expenses fall within § 1920, and both courts have concluded that they do not. In *Brisco-Wade v. Carnahan*, the Eighth Circuit held that "the district court abused its discretion in taxing the mediator's fee against defendants" in part because "section 1920 does not list mediation fees as taxable costs, and we have found no statutory authority . . . permitting the taxation of mediation fees . . . ." 297 F.3d 781, 782 (8th Cir.2002). Similarly, in *Sea Coast Foods*,

Inc. v. Lu-Mar Lobster & Shrimp, Inc., the Ninth Circuit rejected the appellants' attempt to recover mediation fees, concluding that "[n]othing in 28 U.S.C. § 1920 provides for the costs of a mediator." 260 F.3d 1054, 1061 (9th Cir. 2001).[10]

Accordingly, because mediation fees are not explicitly authorized by § 1920, and because this circuit's en banc decision in *Gaddis* does not support the district court's award of mediation fees as taxable costs, we hold that the district court abused its discretion in awarding mediation expenses as taxable costs to Defendants under § 1920 in this ERISA action. *Cf. Mota*, 261 F.3d at 530. We therefore vacate the district court's award of mediation fees.

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10. Several district courts have also agreed that mediation fees should not be taxed as costs under § 1920. *See, e.g., Hodak v. City of St. Peters*, No. 4:04-CV-01099, 2007 WL 674249, *3 (E.D.Mo. Feb. 28, 2007); *Condon v. Hunting Energy Servs. L.P.*, No. H-04-3411, 2006 WL 2882857, *7 (S.D.Tex. Oct.4, 2006); *JES Props., Inc. v. USA Equestrian, Inc.*, 432 F.Supp.2d 1283, 1296 (M.D.Fla.2006); *Zeuner v. Rare Hospitality Int'l, Inc.*, 386 F.Supp.2d 635, 640 (M.D.N.C.2005); *Bernard v. Int'l Portfolio Mgmt., Inc.*, No. 04-CV-60671, 2005 WL 1840157, *5 (S.D.Fla. July 25, 2005); *Firestine v. Parkview Health Sys., Inc.*, 374 F.Supp.2d 658, 672 (N.D.Ind.2005); *Bickers v. U.S. Home Mortgage Corp.*, No. 3:96-CV-0959, 1997 WL 340947, at *2 (N.D.Tex. June 18, 1997).

IV. CONCLUSION

For the reasons stated above, we AFFIRM the district court's order granting summary judgment in favor of Defendants-Appellees and VACATE the award of mediation fees as taxable costs under 28 U.S.C. § 1920.

AFFIRMED IN PART; VACATED IN PART.

APPENDIX B — AMENDED ORDER DENYING MOTION TO ALTER AND AMEND FINAL JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS, FORT WORTH DIVISION DATED DECEMBER 14, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

CIVIL ACTION NO. 4:03-CV-925-Y

COOK CHILDREN'S MEDICAL CENTER,

Plaintiff

VS.

THE NEW ENGLAND PPO MEDICAL PLAN OF GENERAL CONSOLIDATED MANAGEMENT, INC., ET AL.,

Defendants and Third-Party Plaintiffs

VS.

NEW ENGLAND LIFE INSURANCE CO.,

Third-Party Defendant.

Appendix B

AMENDED ORDER DENYING MOTION TO ALTER AND AMEND FINAL JUDGMENT

(with special instruction to the clerk)

The order issued December 7, 2005 [doc. # 98], is VACATED and the following substituted.[1]

Pending before the Court is Plaintiff's motion to alter and amend this Court's final judgment [doc. # 89], filed September 27, 2005. After careful consideration, the Court DENIES the motion.

Absent "highly unusual" circumstances, reconsideration under Rule 59(e) is appropriate only where: (1) the Court committed clear error or the initial decision was manifestly unjust, (2) the Court is presented with newly discovered evidence, or (3) there is an intervening change in controlling law. *See Sch. Dist. No. 1J, Multnomah County, Or. v. AC&S, Inc.*, 5 F.3d 1255, 1262 (9th Cir. 1993). Plaintiff has failed to meet this high threshold. The Court does not express any opinion regarding whether Medicaid would cover an otherwise eligible Medicaid applicant who has insurance available if that insurance coverage is waived. Decision of such an issue is not necessary to the resolution of this case.

SIGNED December 14, 2005.

s/ Terry R. Means
TERRY R. MEANS
UNITED STATES DISTRICT JUDGE

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1. The clerk shall note on the docket of this case that document # 98 is vacated.

APPENDIX C — ORDER GRANTING SUMMARY JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS, FORT WORTH DIVISION DATED SEPTEMBER 14, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

CIVIL ACTION NO. 4:03-CV-925-Y

COOK CHILDREN'S MEDICAL CENTER,

Plaintiff

VS.

THE NEW ENGLAND PPO MEDICAL PLAN OF GENERAL CONSOLIDATED MANAGEMENT, INC., ET AL.,

Defendants and Third-Party Plaintiffs

VS.

NEW ENGLAND LIFE INSURANCE CO.,

Third-Party Defendant.

Appendix C

ORDER GRANTING SUMMARY JUDGMENT

Pending before the Court are three motions for summary judgment: (1) Plaintiff's Motion for Summary Judgment [Doc. # 24], filed November 2, 2004, (2) Defendants' and Third-Party Plaintiffs' Counter Motion to Plaintiff's Motion for Summary Judgment [Doc. # 30], filed November 23, 2004, and (3) Third-Party Defendant's Motion for Summary Judgment [Doc. # 56], filed February 4, 2005. Having carefully considered the motions, responses, and replies, the Court concludes that Defendants' and Third-Party Plaintiff's Counter Motion for Summary Judgment [Doc. # 30] and Third-Party Defendant's Motion for Summary Judgment [Doc. # 56] should be GRANTED. Plaintiff's Motion for Summary Judgment [Doc. # 24] should be DENIED.

I. FACTUAL AND PROCEDURAL BACKGROUND

David G. Miller began working for Creative Education, Inc.—a company affiliated with General Consolidated—on September 22, 2000. On November 29, 2001, Miller's son David C. Miller ("David C") was born, who had congenital heart defects and other disabilities. Initially, Miller placed David C on his wife's health insurance through her employer. Miller's wife left her job a short time later, and Miller added David C as a covered dependent under General Consolidated's insured plan through Aetna US Healthcare. Miller made this change on January 16, 2003, with an effective date of February 1, 2002. It is undisputed that General Consolidated's plan is governed by the Employee

Appendix C

Retirement Income Security Act of 1974 ("ERISA"). 29 U.S.C. §§ 1001-200.

In 2002, General Consolidated decided to no longer fund its ERISA plan through Aetna. General Consolidated replaced the Aetna ERISA plan with a plan of Defendants and Third-Party Plaintiffs—a self-funded health benefit plan under ERISA ("the Plan"), effective April 1, 2002. The open-enrollment period for the Plan began on March 1, 2002. Third-Party defendant New England Life Insurance Co. provided excess-loss coverage and administrative services for the Plan. The Plan stated that waiver of coverage was allowed: "You may elect not to be covered under this Plan for any benefits, or you may waive coverage for all coverages . . . , or you may waive coverage for medical and prescription drug only." In early March, Miller completed an enrollment form and listed David C as one of his dependents to be enrolled in the Plan.

In mid-March, David C was "preadmitted" to plaintiff Cook Children's Medical Center ("the Hospital") for a heart catheterization on April 9 and in-patient heart surgery on April 10. On March 31, 2002, Miller removed David C from enrollment in the Plan by crossing through David C's name and telling Cathy Gunn of General Consolidated to remove David C. Uncontroverted evidence shows that Miller's decision was based on discussions he and his wife had with Medicaid and Social Security Administration officials in their efforts to obtain government aid for David C. These officials told the Millers that David C would be covered by Medicaid for

his care in April 2002 if the Millers did not enroll David C in the Plan. After David C's surgery, Medicaid paid the Hospital for all of the services related to his hospitalization at the contractually and statutorily agreed rate—approximately $70,000.[1] The Hospital returned this payment to Medicaid and instigated this suit against the Plan after it denied payment for David C's charges at the Hospital.

In its motion for summary judgment, the Hospital argues that it is entitled to judgment as a matter of law because the Plan's

> arbitrary and capricious denial of payment of Plan benefits to [the Hospital] as assignee of David C's Plan benefits for its services and products provided to him during the period April 9, 2002, through April 22, 2002, is not supported by the Plan documents, which require payment of Plan benefits to [the Hospital] as assignee of David C's Plan benefits. Such denial is arbitrarily [sic] and capricious.

The Plan argues that it is entitled to summary judgment because it did not arbitrarily and capriciously deny benefits based on Miller's elections and the fact that

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1. Although the Hospital's bills shows the charges to total $145,435.92 [Pl.'s App. to Supp. Reply Br. at tab 1], Medicaid will pay for services only at its discounted rates. *See Rehabilitations Ass'n of Va., Inc. v. Kozolwski*, 42 F.3d 1444, 1447 (4th Cir. 1994).

New England Life makes the payment decisions. New England Life argues that summary judgment in its favor is appropriate because there was "a reasonable and rational basis" to deny payment: David C was not an enrolled dependent under the Plan at the time of the services and Miller knowingly and intentionally waived David C's eligibility.

II. SUMMARY-JUDGMENT STANDARD OF REVIEW

Summary judgment is appropriate when the record establishes "that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." FED. R. CIV. P. 56(c). To determine whether there are any genuine issues of material fact, the Court must first consult the applicable substantive law to ascertain what factual issues are material. *Lavespere v. Niagara Mach. & Tool Works*, 910 F.2d 167, 178 (5th Cir. 1990), *cert. denied*, 510 US. 859 (1993). Next, the Court must review the evidence on those issues, viewing the facts and inferences therefrom in the light most favorable to the nonmovant. *Id.*; *Newell v. Oxford Management Inc.*, 912 F.2d 793, 795 (5th Cir. 1990); *Medlin v. Palmer*, 874 F.2d 1085, 1089 (5th Cir. 1989).

In making its determination on the motion, the Court must look at the full record including the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits. FED. R. CIV. P. 56(c); *see Williams v. Adams*, 836 F.2d 958, 961 (5th Cir. 1988). Rule 56,

however, "does not impose on the district court a duty to sift through the record in search of evidence to support a party's [motion for or] opposition to summary judgment." *Skotak v. Tenneco Resins, Inc.*, 953 F.2d 909, 915-16 & n.7 (5th Cir.), *cert. denied*, 506 U.S. 825 (1992). Instead, parties should "identify specific evidence in the record, and . . . articulate the 'precise manner' in which that evidence support[s] their claim." *Forsyth v. Barr*, 19 F.3d 1527, 1537 (5th Cir. 1994). Still, the Court's function is not to weigh the evidence and determine the truth of the matter, but to determine whether there is a genuine issue for trial. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986).

The party moving for summary judgment has the initial burden of demonstrating that there is no genuine issue as to any material fact and that he is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317 (1986). The moving party need not produce evidence showing the absence of a genuine issue of material fact with respect to an issue on which the nonmovant bears the burden of proof. Rather, the moving party need only point out that the evidentiary documents in the record contain insufficient proof concerning an essential element of the nonmovant's claim. *See id.* at 323-25. But a defendant moving for summary judgment may submit evidence that negates a material element of the plaintiff's claim, show that there is no evidence to support an essential element of the plaintiff's claim, or present evidence supporting an affirmative defense. *Id.* at 322-24; *Buck v. FDIC*, 75 F.3d 1285, 1289 (5th Cir. 1996); *Crescent Towing & Salvage Co. v. M/V Anax*,

40 F.3d 741, 744 (5th Cir. 1994); *Lavespere*, 910 F.2d at 178.

In order for the defendant to negate a material element of the plaintiff's claim, the defendant must negate an element that would affect the outcome of the action. *Anderson*, 477 U.S. at 277. If the defendant moves for summary judgment alleging no evidence to support an essential element of the plaintiff's claim, the defendant need not produce evidence showing the absence of a genuine issue of fact on that essential element. Rather, the defendant need only show that the plaintiff, who bears the burden of proof, has adduced no evidence to support an essential element of his case. *Celotex*, 477 U.S. at 325; *Teply v. Mobil Oil Corp.*, 859 F.2d 375, 379 (5th Cir. 1988).

When the moving party has carried its summary-judgment burden, the nonmovant must go beyond the pleadings and by its own affidavits or by the depositions, answers to interrogatories, or admissions on file, set forth specific facts showing that there is a genuine issue for trial. FED. R. CIV. P. 56(e). This burden is not satisfied with some metaphysical doubt as to the material facts, by conclusory allegations, by unsubstantiated assertions or by only a scintilla of evidence. *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075 (5th Cir. 1994). If the evidence is merely colorable or is not significantly probative, summary judgment may be granted. *Anderson*, 477 U.S. at 249-50.

Appendix C

The once common characterization of summary judgment as a disfavored procedural shortcut no longer applies. Summary judgment is appropriate when the evidence is so weak or tenuous on a material fact that it could not support a judgment in favor of the nonmovant. The nonmovant is entitled to a fair opportunity to discover and produce evidence before the summary judgment record is closed. However, once a motion for summary judgment has pierced the allegations contained in the complaint, the nonmovant must produce or face the potential of an adverse judgment. *See Armstrong v. City of Dallas*, 997 F.2d 62, 66-67 (5th Cir. 1993).

III. DISCUSSION

To show that the Plan and New England Life arbitrarily and capriciously denied coverage for David C's hospital bills, the Hospital must show that they abused the discretion granted under the Plan.[2] *Meditrust Fin. Servs. v. Sterling Chems.*, 168 F.3d 211, 213-16 (5th Cir. 1999). It seems clear in this case that the denial of benefits was neither arbitrary nor capricious. The Plan specifically provided that an employee could opt out of any of the offered benefits. [Third-Party Def's App. in Supp. of Mot. for Summ. J.

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2. The Plan provided that the "Plan Administrator has complete authority to control and manage the Plan. The Plan Administrator has full discretion to determine eligibility, to interpret the Plan and to determine whether a claim should be paid or denied, according to the provisions of the Plan as set forth in this booklet." [Third-Party Def.'s App. in Supp. of Mot. for Summ. J. at 32.]

at 33.] *See In re HECI Exploration Co.*, 862 F.2d 513, 523-25 (5th Cir. 1988) (stating employees may waive their rights to participate in an ERISA plan); *accord Smart v. Gillette Co.*, 70 F.3d 173, 181 (1st Cir. 1995). Miller, during the open-enrollment period, removed David C as a dependent on his enrollment form.[3] [*Id.* at 13, 18.] Miller unequivocally states that he knowingly made this choice with detailed knowledge of the consequences after consultation with officials from Medicaid and the Social Security Administration:

> Neither the Plan, Hansen, General Consolidated, New England nor anyone affiliated with them had any input into my wife's and my decision not to enroll David C. in the Plan. Nothing they said or did caused me to decide not to enroll David C. in the Plan. Additionally, I did not look to any of them for advice on whether to enroll David C. in the Plan and never asked them for any advice. This was a decision that my wife and I made by ourselves after discussing the matter with people affiliated with Medicaid and The Social Security Administration.

---

3. The Hospital implies a concession that this action opted David C out of the Plan: "*Without more*, David C, a dependent of David G Miller who was covered under the employer's prior plan insured by Aetna US Heathcare was, by the specific terms of the Plan, enrolled in the new Defendant Plan on April 1, 2002." (Emphasis added). [Plf.'s Resp. to Third-Party Def.'s Mot. for Summ. J. at 5.] Certainly Miller's actions constitute something "more."

Appendix C

> ... When I instructed General Consolidated not to enroll David C. in General Consolidated's ERISA Plan, I knew I had the opportunity to have David C. as a named dependent under my health plan. However, I intentionally and voluntarily relinquished my right and David C.'s right to have him named as a dependent and plan member under my employer's ERISA health plan. I am college educated and had close to a month to make this decision. I had the opportunity to speak to an attorney or seek other assistance. This decision was made after multiple conversations with representatives of Medicaid and The Social Security Administration. From our perspective, this decision was made by my wife and I in the best interests of my family and David C. I did not intend to mislead anyone by removing my son from the enrollment form. I do not feel that I have been misled by anyone. [*Id.* at 3-4.]

The fact that Miller's decision was arguably incorrect regarding David C's eligibility for Medicaid does not render his waiver involuntary.[4] *See Smart*, 70 F.3d at 181 (holding valid waiver of ERISA plan occurs when party knows he possesses right to participate and that, by waiving such right, he is relinquishing a benefit).

---

4. But the summary-judgment evidence shows that David C received Medicaid benefits for the hospital stay; thus, the Hospital's argument that David C was not entitled to such benefits is specious. [Pl.'s 2nd Supp. to Joint Written Report on Settlement Conference at Ex. 1.]

Appendix C

The Hospital's argument that Miller was mistaken that David C would be eligible to receive Medicaid and was a victim of "misinformed confusion" cannot surmount the uncontradicted evidence from Miller that his waiver was, indeed, informed. [Pl.'s Resp. to Third-Party Def.'s Mot. for Summ. J. at 8.] Further, neither the Plan nor New England Life was required to explain the consequences of Miller's waiver—especially when Miller never inquired of them what the consequences would be. *See Switzer v. Wal-Mart Stores, Inc.*, 52 F.3d 1294, 1299 (5th Cir. 1995). Thus, Miller either ensured that David C was not enrolled in the Plan or knowingly and voluntarily waived David C's benefits under ERISA. *See HECI*, 862 F.2d at 523-25; *accord Smart*, 70 F.3d at 181.

The Hospital argues that Miller's election during the open-enrollment period is not effective because the Plan did not exist before April 1. [*Id.* at 5.] Taking the Hospital's argument to its necessary conclusion, the provision of the Plan allowing employees to opt out of any benefits would be rendered meaningless, and a plan participant would be precluded from electing to not participate in a plan. Indeed, during the open-enrollment period, Miller had an existing right to enroll or not enroll David C in the Plan.

IV. CONCLUSION

Because Miller knowingly and voluntarily waived David C's coverage under the Plan and elected not to have David C included as a covered dependent and because the Plan and New England Life had a valid basis for denying coverage, the Hospital is not entitled to summary judgment. However, the Plan and New England Life are entitled to summary judgment as a matter of law.

SIGNED September 14, 2005.

s/ Terry R. Means
TERRY R. MEANS
UNITED STATES DISTRICT JUDGE

APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT DENYING PETITION FOR REHEARING FILED AUGUST 1, 2007

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 06-10511

COOK CHILDREN'S MEDICAL CENTER

Plaintiff - Counter Defendant - Appellant

v.

THE NEW ENGLAND PPO PLAN OF GENERAL CONSOLIDATED MANAGEMENT INC; DEBORAH HANSEN, Fiduciary of The New England PPO Medical Plan of General Consolidated Management, Inc.

Defendants - Counter Claimants - Appellees

NEW ENGLAND LIFE INSURANCE COMPANY

Third Party Defendant - Appellee

Appeal from the United States District Court for the Northern District of Texas, Fort Worth

Appendix D

ON PETITION FOR REHEARING

Before KING, GARZA, and PRADO, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing is DENIED.

ENTERED FOR THE COURT:

s/ Edward Prado
United States Circuit Judge

79

(2)

No. 07-576

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2008
OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE

Supreme Court of the United States

COOK CHILDREN'S MEDICAL CENTER,

Petitioner,

v.

THE NEW ENGLAND PPO PLAN OF GENERAL CONSOLIDATED MANAGEMENT, INC; DEBORAH HANSEN, FIDUCIARY, and NEW ENGLAND LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT NEW ENGLAND LIFE INSURANCE COMPANY

MICHAEL AUSTIN HATCHELL, ESQ.
Counsel of Record
JASON SANDERS
CARL C. SCHERZ
KIRSTEN M. CASTAÑEDA
LOCKE LORD BISSELL & LIDDELL LLP
2200 Ross Avenue
Suite 2200
Dallas, Texas 75201-6776
(214) 740-8000

Attorneys for Respondent New England Life Ins. Co.

213304

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

COUNTERSTATEMENT OF QUESTIONS PRESENTED

David G. Miller prospectively elected not to enroll his son, David C., in his employer's self-funded ERISA health plan. This election was in accordance with the Summary Plan Description (which expressly allowed employees to opt out of any offered benefits) and ERISA (which permits an employee to opt out of an employee benefit plan). When Petitioner thereafter submitted a claim for medical services rendered to David C., the Plan Administrator denied it.

Was the Plan Administrator's decision an abuse of discretion?

CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Court Rule 29.6, Respondent New England Life Insurance Company makes the following disclosures:

Respondent New England Life Insurance Company is wholly owned by New England Holdings, Inc.

TABLE OF CONTENTS

	Page
Counterstatement of Questions Presented	i
Corporate Disclosure Statement	ii
Table of Cited Authorities	iv
Summary of the Case	1
Statement of Lack of Jurisdiction	2
Statement of the Case	3
Reasons for Denying the Petition	6
A. No Basis For Discretionary Review Exists	6
B. The Plan Administrator's Decision Was Properly Upheld Under The Time-Tested ERISA Standard	7
C. Public Policy Does Not Support A Different Result	11
Prayer	13

TABLE OF CITED AUTHORITIES

Page

CASES

Anthony v. Sullivan,
954 F.2d 289 (5th Cir. 1992) 8

Barnett v. Kaiser Found. Health Plan, Inc.,
832 F.3d 413 (9th Cir. 1994) 8

Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan,
201 F.3d 335 (4th Cir. 2000) 8

Carr v. Gates Health Care Plan,
195 F.3d 292 (7th Cir. 1999) 8

Deters v. Secretary of Health, Educ. & Welfare,
789 F.2d 1181 (5th Cir. 1986) 8

Ellis v. Liberty Life Assur. Co.,
394 F.3d 262 (5th Cir. 2005) 8, 9

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101, 109 S.Ct. 948 (1989) 6, 7

Fletcher-Merrit v. NorAm Energy Corp.,
250 F.3d 1174 (8th Cir. 2001) 8

Geddes v. United Staffing Alliance Employee Medical Plan,
469 F.3d 919 (10th Cir. 2006) 8

Cited Authorities

Page

Gillam v. Nevada Power Co.,
488 F.3d 1189 (9th Cir. 2007) 6

HECI Exploration Co. v. Holloway,
862 F.2d 513 (5th Cir. 1988) 9

Hubbard v. U.S.,
514 U.S. 695, 115 S.Ct. 1754 (1995) 2, 7

Kosakow v. New Rochelle Radiology Assocs., P.C.,
274 F.3d 706 (2d Cir. 2001) 6

Laniok v. Advisory Comm. of the Brainerd Mfg. Co. Pension Plan,
935 F.2d 1360 (2d Cir. 1991) 9-10

Leahy v. Raytheon Co.,
315 F.3d 11 (1st Cir. 2002) 6

Meditrust Fin. Servs. v. Sterling Chems.,
168 F.3d 211 (5th Cir. 1999) 7, 8, 9

STATUTES AND REGULATIONS

42 C.F.R. § 433.139(b)(1) 11

29 U.S.C. § 1002(8) 9

29 U.S.C. § 1053(b)(1)(B) 10

29 U.S.C. § 1104(a)(1)(D) 10

Cited Authorities

Page

COURT RULES

SUP. CT. R. 10 ..... 1, 2, 3, 7

SUP. CT. R. 10(a) 2

SUP. CT. R. 10(b) 2

SUP. CT. R. 10(c) 2

SUP. CT. R. 29.6 ii

SUMMARY OF THE CASE

This case does not involve any of the grounds set forth in Supreme Court Rule 10 or any compelling reason to justify discretionary review. Instead, this case seeks review of an ERISA plan administrator's well-founded decision to deny a routine claim for benefits.

When Petitioner Cook Children's Medical Center ("Cook") accepted David C. as a patient for the medical care in question, Cook did so with the understanding that David C. would be covered by Medicaid at Medicaid's discounted rate. (*See* R4:103, 58 at 223-24.) Thereafter, Cook accepted payment from Medicaid. (R4:103, 58 at 215; *id.* at 258.) Cook later returned the discounted payment to Medicaid and sought reimbursement – at higher rates – from the self-funded ERISA health plan (the "Plan") offered by David C.'s father's employer. (R4:103, 58 at 258; 215 [Ex. 4 – APP. 215].)

However, David C.'s father ("Mr. Miller") had previously elected not to enroll David C. in the Plan. (R4:103, 58 at 3.) Therefore, David C. was not enrolled in the Plan at the time Cook provided medical services. (*Id.*) Accordingly, the Plan Administrator denied Cook's claim, (R4:103, 58 at 15,) Both the district court and the court of appeals found that there was substantial evidence to support the Plan Administrator's decision and that, as a matter of law, the Plan Administrator did not abuse her discretion.

STATEMENT OF LACK OF JURISDICTION

This case does not provide grounds for the Court's discretionary review. Cook has not identified any opinion from this Court, another U.S. court of appeals, or state court of last resort that conflicts with the Fifth Circuit's opinion below. *See* SUP. CT. R. 10(a),(c). Nor does Cook seek review of an opinion from a state court of last resort. *Id.* at 10(b).

Furthermore, this case does not involve an important question of federal law requiring the Court's attention. *Id.* at 10(c). Instead, this case simply seeks review of an ERISA plan administrator's decision to deny a claim for benefits. The applicable standards are well established.

Cook attempts to inject controversy into the Fifth Circuit's opinion by arguing that Mr. Miller's decision not to enroll his child in an ERISA plan was contrary to Medicaid and public policy. However, as shown in Section C, below, neither Medicaid nor public policy prohibited Mr. Miller from exercising his right *not* to enroll David C. Moreover, neither the judicial system nor ERISA has ever imposed a requirement upon a plan administrator to determine, in considering a claim, whether a plan participant's prior election comported with Medicaid law.

This case does not represent a conflict or departure from precedent and does not present any important question of federal law. Because there is no compelling reason for review, the Petition should be denied. *See* SUP. CT. R. 10; *Hubbard v. U.S.*, 514 U.S. 695, 720, 115 S.Ct. 1754, 1767 (1995) (Rehnquist, C.J., dissenting)

(stating general principle that Supreme Court Rule 10 "embodies the standards by which we decide to grant review").

STATEMENT OF THE CASE

Through his employer, Mr. Miller received the opportunity to participate in the Plan. (R4:103, 58 at 13.) Mr. Miller's employer contracted with New England Life Insurance to provide certain administrative services to the Plan. (*See id.*) Respondent Deborah Hansen was the Plan Administrator. (*Id.* at 103.)

The Plan's open enrollment period began on March 1, 2002 and ended on March 31, 2002. (R4:103, 58 at 13.) The Plan's effective date was April 1, 2002. (*Id.*) At the inception of the open enrollment period, Mr. Miller listed David C. on his enrollment form as one of his dependents to be enrolled in the Plan. (*Id.* at 2, 13.) However, on March 31, 2002 – still during open enrollment and before the effective date of the Plan – Mr. Miller removed David C. from his enrollment form by crossing through David C.'s name. (R4:103, 58 at 2-3, 13, 193.) He also told the Plan Administrator to remove David C. from his enrollment application. (*Id.*) Pursuant to Mr. Miller's instructions, the Plan Administrator did not enroll David C. in the Plan. (*Id.*)

Mr. Miller, who is college educated, had nearly a month to make the enrollment decision. (R4:103, 58 at 2-3.) He had the opportunity to speak to an attorney or seek other assistance if he wanted to do so. (R4:103, 58 at 3.) In deciding whether to enroll David C. in the Plan, Mr. Miller did not look to or ask the Plan, Plan

Administrator, New England, General Consolidated, or anyone affiliated with them for advice. (R4:103, 58 at 3.) Nothing they said or did caused Mr. Miller to decide not to enroll David C. in the Plan. (*Id.*)

Instead, Mr. Miller made his decision voluntarily after he and his wife consulted with various Medicaid and Social Security Administration officials. (*Id.*) From the Millers' perspective, they decided to remove David C.'s name from the enrollment form in the best interests of David C. and the family. (R4:103, 58 at 3-4.) They did not intend to mislead anyone by exercising their right not to enroll their son in the Plan, and they do not feel that anyone has misled them. (*See* R4:103, 58 at 4.)

Thereafter, from April 9, 2002 through April 22, 2002, David C. underwent medical treatment at Cook. (R4:103, 58 at 4.) The evidence shows, and Cook acknowledged in its briefing below, that Cook knowingly accepted David C. as a patient for this care with the understanding that Medicaid would be the payor. (R:103, 58 at 223-24.)

In fact, Medicaid did pay Cook for all of the services at issue in this matter. (R4:103, 58 at 215.) Medicaid used the rate set by Medicaid's contract with Cook, which resulted in a payment of approximately $76,291.63. (*Id.*) Subsequently, Cook returned that payment and demanded payment from the Plan for $138,000.00. (R4:103, 58 at 258; *id.* at 215; AB at 6.)

Upon receipt of Cook's demand, the Plan Administrator reviewed the Summary Plan Description and the administrative record. (R4:103, 58 at 15.) The Plan provides that "[t]he Plan Administrator has

complete authority to control and manage the Plan. The Plan Administrator has full discretion to determine eligibility, to interpret the Plan and to determine whether a claim should be paid or denied, according to the provisions of the Plan as set forth in this booklet." (R4:103, 58 at 33.)

The Summary Plan Description further provides that the employee "may elect not to be covered under this Plan for any benefits or you may waive coverage for all coverages except Life and AD&D Insurance, or you may waive coverage for medical and prescription drug only." (R4:103, 58 at 32; RE at Tab 1.) Because David C. was not enrolled in the Plan during April 2002, David C. was not eligible for the benefits sought by Cook. (R4:103, 58 at 15.) Accordingly, the Plan denied Cook's request for payment. (*Id.*)

Cook filed suit to recover these benefits and had approximately a year to conduct discovery and take any depositions that it felt were necessary. (R1:21 at 8; R3:88 at 436.) On September 14, 2005, the district court granted summary judgment in favor of New England, the Plan, and the Plan Administrator and denied relief to Cook. (R2:88 at 436.) On appeal, the Court of Appeals for the Fifth Circuit properly applied the summary judgment and ERISA standards of review. *Petition* at 9a-13a. Like the district court, the court of appeals found that the Plan Administrator did not abuse her discretion in denying Cook's benefits claim. *Id.* at 14a-16a.

Unsatisfied with this result, Cook now petitions the Court to review and reverse both the court of appeals' and the district court's well-reasoned and amply-

supported determinations that the ERISA Plan Administrator did not abuse her discretion in denying benefits to Cook.

REASONS FOR DENYING THE PETITION

Cook's Petition focuses on a single issue: whether Mr. Miller's knowing and voluntary election to exercise his legal right not to enroll his son in an ERISA plan violated public policy. Cook does not dispute in its Petition that the administrative record fully supports the Plan Administrator's decision. Instead, Cook contends that the lower courts should have departed from the well-accepted standard of review, ignored the fact that the administrative record supported the Plan Administrator's decision, and invalidated the waiver based on public policy principles.

A. No Basis For Discretionary Review Exists

There is no basis for the Court to exercise its discretion and review this case. Cook requests review of an ERISA plan administrator's decision to deny a claim for benefits. It is well established that, when an ERISA plan grants discretion to a plan administrator, courts review the administrator's benefit determination for abuse of discretion. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 957 (1989) (setting forth basic standard); *see also, e.g., Gillam v. Nevada Power Co.*, 488 F.3d 1189, 1193 (9th Cir. 2007) (discussing basic *Firestone* framework); *Leahy v. Raytheon Co.*, 315 F.3d 11, 15 (1st Cir. 2002) (applying *Firestone* "ground rules"); *Kosakow v. New Rochelle Radiology Assocs., P.C.*, 274 F.3d 706, 737-38 (2d Cir. 2001)

(determining standard in accordance with *Firestone* and "several past [Second Circuit] decisions"); *Meditrust Fin. Servs. v. Sterling Chems.*, 168 F.3d 211, 213 (5th Cir. 1999) (applying basic *Firestone* standard).

Cook attempts to gain footing by arguing that the plan participant's knowing and voluntary decision not to enroll his child in an ERISA plan was contrary to Medicaid and public policy. As shown in Section C, neither Medicaid nor public policy required Mr. Miller to enroll David C. in the Plan. Nor was the Plan Administrator required to look beyond the claim and determine whether Mr. Miller's decision not to enroll David C. violated Medicaid or public policy.

Because there is no basis to grant review, the petition should be denied. *See* SUP. CT. R. 10; *Hubbard*, 514 U.S. at 720, 115 S.Ct. at 1767 (Rehnquist, C.J., dissenting) (stating general principle that Supreme Court Rule 10 "embodies the standards by which we decide to grant review").

B. The Plan Administrator's Decision Was Properly Upheld Under The Time-Tested ERISA Standard

If an ERISA plan grants a plan administrator discretion, the administrator's benefit determinations are reviewed for abuse of discretion. *See Firestone*, 489 U.S. at 115, 109 S.Ct. at 957; *Meditrust Fin.*, 168 F.3d at 213. An administrator abuses her discretion only when she acts in an "arbitrary and capricious" manner. *Meditrust Fin.*, 168 F.3d at 214-16. A decision is

arbitrary only if made without a rational connection between: (1) the known facts and the decision; or (2) the found facts and the evidence. *Id.* at 215.

"When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, [a court will] affirm an administrator's decision if it is supported by substantial evidence." *See id.* at 215. Only a minimal showing is required to satisfy the "substantial evidence" standard. *See Ellis v. Liberty Life Assur. Co.*, 394 F.3d 262, 273 (5th Cir. 2005). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* at 273. It must be more than a scintilla but is less than a preponderance. *Id.*; *see also Anthony v. Sullivan*, 954 F.2d 289, 295 (5th Cir. 1992); *Deters v. Secretary of Health, Educ. & Welfare*, 789 F.2d 1181, 1185 (5th Cir. 1986).

The reasonableness of an administrator's interpretation should be the focus of the court's inquiry – not whose interpretation of the plan is most persuasive. *Barnett v. Kaiser Found. Health Plan, Inc.*, 32 F.3d 413, 416 (9th Cir. 1994); *see also Geddes v. United Staffing Alliance Employee Medical Plan*, 469 F.3d 919, 929 (10th Cir. 2006); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 (8th Cir. 2001); *Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 201 F.3d 335, 344 (4th Cir. 2000); *Carr v. Gates Health Care Plan*, 195 F.3d 292, 294 (7th Cir. 1999). Thus, when a court reviews a plan administrator's waiver determination, the central inquiry is not whether the party, in fact, waived his right, "but whether the Plan administrator acted arbitrarily or capriciously *in determining* that [the party] had

waived his rights." *HECI Exploration Co. v. Holloway*, 862 F.2d 513, 523 (5th Cir. 1988) (emphasis in original).

A claimant bears the burden of proving that a plan or plan administrator abused its discretion. *See id. at* 523 n.17. However, a district court is not required to rule in favor of an ERISA claimant merely because it has supported its claim with substantial, or even a preponderance of, evidence. *Ellis*, 394 F.3d at 273. To the contrary, if the *plan administrator's* decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail. *Id.*

In the case at hand, the Plan Administrator did not abuse her discretion. It is undisputed that David C. was not enrolled in the Plan at the time the services were provided. (R4:103, 58 at 13.) Because Mr. Miller elected not to enroll David C. under the Plan, David C. was not covered by the Plan for these services. Consequently, there was substantial evidence to support the Plan Administrator's decision, and a rational connection existed between the known facts and evidence and the found facts and decision to deny Cook's claim. *See Meditrust Fin.*, 168 F.3d at 215.

In fact, the Plan Administrator had no authority or discretion to approve and pay Cook's claim. The Plan itself provided that an employee could elect not to be covered in whole or in part. (R4:103, 58 at 33; RE at Tab 1.) Similarly, Congress has provided that an ERISA plan participant has the right to designate his/her beneficiaries, *see* 29 U.S.C. § 1002(8), and need not participate in an ERISA plan. *See e.g., Laniok v. Advisory Comm. of the Brainerd Mfg. Co. Pension Plan*,

935 F.2d 1360, 1365 (2d Cir. 1991); 29 U.S.C. § 1053(b)(1)(B). Thus, the Plan Administrator had no discretion under ERISA to do anything but follow Mr. Miller's instructions not to enroll David C. and deny Cook's claim. *See* 29 U.S.C. § 1104(a)(1)(D) (requiring that a plan administrator discharge her duties in accordance with the documents and instruments governing the plan).

Cook essentially argues that the Plan Administrator should have negated Mr. Miller's enrollment decision and retroactively deemed David C. as enrolled, based on the contention that Mr. Miller's decision violated laws other than ERISA. As the Fifth Circuit correctly noted in its underlying opinion, neither the courts nor ERISA have ever imposed a requirement upon a plan administrator to determine, in considering a claim, whether a plan participant's prior election comported with Medicaid law. *Petition* at 14a. They should not. It is unreasonable and unworkable to require ERISA plan administrators to look beyond ERISA and the administrative record and determine whether a participant's enrollment decision violated any other laws or public policy. Plan administrators do not have the expertise or qualifications to make such a determination. Furthermore, the burden of such a requirement would dramatically increase the costs incurred by ERISA plans, thus defeating ERISA's purpose.

Cook has not provided any basis for this Court to reach a decision different from the district court's and court of appeals' determination. The Plan Administrator did not abuse her discretion.

C. Public Policy Does Not Support A Different Result

Cook argues that Mr. Miller's decision not to enroll David C. contravened Medicaid and public policy. Neither Medicaid nor public policy requires a person to enroll himself or his children in an ERISA benefit health plan. Medicaid simply provides rules and standards that apply *if a person chooses to enroll in a private insurance plan.*

Cook notes that federal policy and law require Medicaid to be the payor of last resort. *Petition* at 7. This principle is not at issue here. Certainly, if a person has chosen to enroll in a private insurance plan and the claim is covered, Medicaid will be secondary to the private insurance plan. *Id.*; 42 C.F.R. § 433.139(b)(1). However, in this case, Mr. Miller lawfully and prospectively chose not to enroll David C. in the Plan. Because David C. was not enrolled in the Plan at the time Cook provided services and there was no private insurance, Medicaid was the payor of last resort, in accordance with law and any underlying policy.

In addition, Cook contends that a misrepresentation or failure to disclose the facts when attempting to obtain Medicaid benefits is contrary to both the law and public policy. *Petition* at 8. For instance, if Mr. Miller had chosen to enroll David C. in the Plan at the outset, and then had lied about David C.'s enrollment (or failed to disclose it), then he may have violated the law. However, the facts of the case are dramatically different. There is no evidence of any dishonesty or misrepresentation by Mr. Miller or any of the Miller family, to the government or to Cook.

Instead, the evidence shows that:

(1) the Summary Plan Description gave Mr. Miller the option not to enroll for all or part of the benefits offered;

(2) there is no law – Medicaid-related or otherwise – that forbade the Plan from making enrollment optional or that required Mr. Miller to enroll to the full limits of the Plan;

(3) Mr. Miller and his wife consulted openly with Medicaid and Social Security Administration representatives about their decision;

(4) during the Plan enrollment period, Mr. Miller chose not to enroll David C. in the Plan and communicated this election to the Plan in several ways;

(5) David C. received medical services from Cook during the time he was not enrolled in the Plan; and

(6) Cook expected to receive payment from Medicaid when it admitted David C and, in fact, received payment from Medicaid at the agreed-upon Medicaid rate.

This is not a dispute regarding a plan's or insured's attempt to evade Medicaid law or public policy. Rather, this is a case in which Cook asks the judicial system to rewrite the private agreement between the Plan and Mr.

Miller, to create ERISA insurance coverage where none exists, and to effectively legislate new language and policy into Medicaid statutes that would require U.S. citizens to enroll to the full limit in any and all reasonably available insurance. Had Congress wanted to impose this requirement on its constituency, it could have done so. No such requirement appears in any of the laws or regulations cited by Cook.

PRAYER

Respondent New England Life Insurance Company prays that the Court deny the Petition for Writ of Certiorari and the relief requested therein.

Respectfully submitted,

MICHAEL AUSTIN HATCHELL, ESQ.
Counsel of Record
JASON SANDERS
CARL C. SCHERZ
KIRSTEN M. CASTAÑEDA
LOCKE LORD BISSELL & LIDDELL LLP
2200 Ross Avenue
Suite 2200
Dallas, Texas 75201-6776
(214) 740-8000

Attorneys for Respondent
New England Life Ins. Co.

81

(3)

No. 07-576

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IN THE

Supreme Court of the United States

COOK CHILDREN'S MEDICAL CENTER,

Petitioner,

v.

THE NEW ENGLAND PPO PLAN OF GENERAL CONSOLIDATED MANAGEMENT INC; DEBORAH HANSEN, FIDUCIARY and NEW ENGLAND LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

REPLY BRIEF

THOMAS L. FREYTAG
P.O. Box 600124
Dallas, TX 75360
(214) 363-9501

Attorney for Petitioner

213527

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

STATEMENT PURSUANT TO RULE 29.6

Petitioner's Rule 29.6 Statement was set forth at page *ii* of its Petition for a Writ of Certiorari, and there are no amendments to that Statement.

TABLE OF CONTENTS

	Page
STATEMENT PURSUANT TO RULE 29.6 ..	i
TABLE OF CONTENTS	ii
TABLE OF CITED AUTHORITIES	iii
ARGUMENT	1
I. Respondent does not address the Question Presented.	1
II. David C. was automatically covered by the Plan.	1
III. The Administrator's interpretation of the Plan was not legally correct.	2
IV. The Administrator's denial of the claim was an abuse of discretion.	3
A. The relevant regulations.	4
B. The factual background.	5
CONCLUSION	6

TABLE OF CITED AUTHORITIES

Page

Cases:

United of Omaha Life Ins. v. Sun Life Ins., 894 F.2d 1555 (11th Cir. 1990) 2

Wildbur v. ARCO Chemical Co., 974 F.2d 631 (5th Cir. 1992) 2, 3, 4

Petitioner COOK CHILDREN'S MEDICAL CENTER replies to the Brief in Opposition for Respondent New England Life Insurance Company:

ARGUMENT

I. Respondent does not address the Question Presented.

Respondent's brief does not respond to the Question Presented in Cook Children's petition for certiorari, which is: Did the court below err in enforcing Mr. Miller's waiver of available ERISA plan health care benefits for David C. under Respondent's ERISA Plan when the sole purpose of the waiver was to obtain Medicaid benefits in contravention of the public policy that any person with available ERISA health care plan benefits or private health care insurance cannot obtain Medicaid benefits.

Instead of addressing the question, Respondent sidesteps by presenting its own "Counterstatement of Questions Presented" (Respondent's Brief, p. 1), in which Respondent mistakenly argues, as it repeatedly does in the balance of its brief, that "Mr. Miller elected to not enroll his son David C." in the Respondent plan.

II. David C. was automatically covered by the Plan.

Respondent's "elected to not enroll" argument is a fallacious conclusion based upon the false assumption Mr. Miller was required to enroll his son in the Plan to obtain its coverage. To the contrary, the Summary Plan Description provides that Respondent's Plan *automatically* covered those persons who were covered

by the employer's prior plan on the date the prior plan terminated. (*See* Cook Children's Record Excerpts, Tab 6, p.1.) Automatic coverage dispenses with any necessity to enroll such persons in Respondent's Plan. *United of Omaha Life Ins. v. Sun Life Ins.*, 894 F.2d 1555, 1559 (11th Cir. 1990). ("Because Wells was automatically covered by the basic insurance of the group policy, no application was necessary.") It is undisputed that David C. was covered by the employer's prior plan on the date that the prior plan was terminated. As Respondent's brief (p.5) admits, Respondent's Summary Plan Description provided that the employee could (1) elect not to be covered or (2) waive all coverages except Life and AD&D Insurance or (3) waive coverage for medical and prescription drugs only. However, Mr. Miller did not "elect not to be covered", since it is undisputed by Respondent that Mr. Miller, his wife, and two of his three children were covered by Respondent's Plan.

The fact is that Mr. Miller did not "choose to not enroll David C in the Plan", (as Respondent now asserts, but rather chose to *waive the coverage* for David C under the Plan (as Respondent asserted in the courts below); and it is undisputed that Mr. Miller did so to qualify his son to receive Medicaid benefits.

III. The Administrator's interpretation of the Plan was not legally correct.

In *Wildbur v. ARCO Chemical Co.*, 974 F.2d 631, 637-638 (5th Cir. 1992), the Court detailed the two-step procedure to be followed when a court reviews a plan administrator's decision on a claim. *First, the court must determine the legally correct interpretation of the plan.*

If the administrator did not give the plan the legally correct interpretation, the court must *then determine whether the administrator's decision was an abuse of discretion.* In determining whether the administrator's interpretation of the plan was legally correct, the court must consider, *inter alia,* whether the administrator's *interpretation is consistent with a fair reading of the plan.*

Respondent argues that the Administrator was not required to consider relevant law in deciding Cook Children's claim. However, *Wildbur* teaches that the *reviewing court* must determine whether the Administrator's interpretation of the Plan was *legally correct* and if not, whether the decision was an abuse of discretion, considering the *relevant regulations* and the factual background.

Respondent's brief and the Administrator's decision are both predicated on the incorrect and unwarranted interpretation that the Plan did not cover David C. unless Mr. Miller chose to enroll him. This is *not consistent* with a fair reading of the Plan. Under a fair reading of the Summary Plan Description, David C. *was automatically covered* by the Plan and there was no need for him to be "enrolled" to have the benefit of such coverage.

IV. The Administrator's denial of the claim was an abuse of discretion.

Since the Administrator failed to apply the legally correct interpretation of Respondent's Plan, under the procedure detailed in *Wildbur* at pp. 637-638, the reviewing courts were required to determine whether

the Administrator's denial of Cook Children's claim for services rendered to David C, was an abuse of discretion. In making this determination, the reviewing courts were required by *Wildbur* to consider, *inter alia,* (**a**) "any relevant regulations formulated by the appropriate administrative agencies" and (**b**) "the factual background of the determination and any inferences of lack of good faith."

A. The relevant regulations.

Cook Children's petition for certiorari cites statutes and regulations establishing the public policy that any person who has available health care plan benefits or health care insurance cannot obtain Medicaid benefits. Waiving available resources such as private insurance or ERISA plan health care benefits for the purpose of qualifying for Medicaid benefits contravenes that public policy. Respondent's brief (p. 11) concedes that public policy forbids a person from obtaining Medicaid benefits if that person has private health care plan benefits or health care insurance available.

Respondent's brief (p. 11) asserts that "if Mr. Miller had chosen to enroll David C, in the Plan at the outset, and then had lied about it (or failed to disclose it), then he may have violated the law." This supposed scenario differs little from what are the undisputed facts of this case, to-wit,

(1) David C. was automatically covered by the Plan at the outset and no act by Mr. Miller was necessary to secure such coverage; and

(2) in obtaining medical services for David C. from Cook Children's, Mr. Miller not only failed to disclose that David C. was automatically covered by the Plan, but in addition represented that Medicaid was primarily responsible to pay for such services, thereby implying that no private ERISA benefits or insurance was available.

B. The factual background.

The undisputed factual background is that Mr. Miller purposefully waived coverage of his son David C. by the Plan in attempting to qualify his son to receive Medicaid benefits. Such a waiver plainly contravenes public policy, and the question is whether the courts below erred by enforcing such a waiver.

Respondent concedes that Medicaid is secondary to a private insurance plan, but asserts, without any reference to statutory, regulatory or case law authority in support thereof, that this public policy is overruled at the whim of a seeker of public Medicaid benefits by the simple waiver of available ERISA health care plan benefits or private health care insurance. (Respondent's Brief, p 11.) Public policy should not be treated so whimsically.

CONCLUSION

Enforcement of Mr. Miller's waiver circumvents established public policy that health care paid for by public funding is reserved for persons without private resources to pay, and provides a "how-to-get-on-Medicaid" primer for persons with private resources who are dissatisfied with the co-pay requirements or other terms and conditions of their available private insurance or ERISA plan health care benefits. A simple waiver of that insurance or plan benefits will do it. Such ought not be.

This is an important question of federal law that, left unreviewed, would substantially adversely affect the federal treasury to the benefit of private ERISA health care plans and private health care insurance carriers.

Certiorari should be granted.

Respectfully submitted,

THOMAS L. FREYTAG
P.O. Box 600124
Dallas, TX 75360
(214) 363-9501

Attorney for Petitioner